Arizona Health Care Cost Containment System

January-February, 2003

ENCOUNTER KEYS

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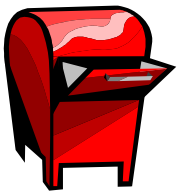

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UNIVERSAL BILLING

When submitting Universal Billing (UB) encounters all information must be submitted on the encounter. Research indicates UBs are pending due to missing or incorrect pertinent information such as, patient status, admission type, and discharge hour.

Error codes associated with these missing fields are: U425 - Patient Status Required On In-Patient/LTC and U430 – Admit Type Required on UB92 O/P and I/P.

Research has also found encounters pending for error code U450 – Admit Hour Is Later Than Discharge Hour. Encounters are being submitted where the admit hour is later than the discharge hour. The discharge hour cannot be prior to the admit hour for a single service date institutional encounter. For example, the beginning and ending date of service is 5/11/01, admit hour is 10, and discharge hour is 00. This means that the patient was admitted at 10 am on 5/11/01 and discharged at midnight on 05/11/01.

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UPDATED AHCCCS FEE-FOR-SERVICE PROVIDER MANUAL

The AHCCCS Fee-For-Service Provider Manual has been updated and is available on the AHCCCS Website.

To view or download the manual go to AHCCCS Website at www.ahcccs.state.az.us. Click on “Information for Providers” on the left side of the AHCCCS home page. Scroll down the “Providers” page to the “Additional Information” section. Click on the Fee-For-Service Provider Manual link. http://www.ahcccs.state.az.us/Publications/provman/providers.htm

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DILEMMAS

For the months of January and February the following error code conditions are not subject to sanction.

S385 – Service Units Exceed Maximum Allowed (80000 procedure codes and service units less than twice the limit).

P015 - Service Provider Type Invalid For Uniform Billing Form (applies to the new provider types A1, A2, A3, A5, B1, B2, B3, B5, B6, B7)

S841 - ASC Procedure Code Is Not Covered

S842 - ASC Procedure Code is Not Classified

REVISED FEE-FOR-SERVICE FEE SCHEDULE RATES

AHCCCS revised its Fee-For-Service (FFS) fee schedule payment rates for the following codes. These new rates are for dates of service on or after October 1, 2002:

Q3030	Sodium Hyaluronate, Per 20-25 Mg Dose /Intra-Articular	$	105.64
K0563	Ostomy Skin Barrier,With Flange (Solid/Flexible/Accordion)	$	8.66
K0564	Ostomy Skin Barrier, With Flange (Solid/Flexible/Accordion)	$	9.76
K0567	Ostomy Pouch/Drainable With Karaya Based Barrier Attach	$	2.04
K0570	Ostomy Skin Barrier/With Flange (Solid/Flexible Or Accordion)	$	4.88
G0245	Initial Foot Exam Pt Lops	$	60.94
G0246	Follow Up Evaluation Of Foot Pt Lops	$	35.76
G0247	Routine Foot Care Patient With Lops	$	39.47
G0248	Demonstration Use Of Home Inr Monitoring	$	99.88
G0249	Provision Of Test Materials And Equipment	$	70.85
G0250	Physician Review Interpertation & Patient Management	$	9.71
G0219	Pet Imaging Whole Body; Melanoma for Non-Covered Ind.	$	2,045.29
G0253	Pet Image Breast Detection Recur	$	2,045.29
G0254	Pet Image Breast Evaluation to Treatment	$	2,045.29

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ADJUSTMENTS/VOIDS

Chapter 9 of the Encounter Reporting User Manual has specific instructions on how to make a successful adjustment, void or replacement to an encounter. For error codes:

- H270 (Prior CRN Not Found or Mismatched) and
- H280 (Encounter Not Eligible for Adjustment/Void)

The Plan must first verify that the original CRN has been adjudicated (31/78). Do not make adjustments on encounters that are pending (in location 11/92) and on encounters that have been withdrawn (location 42/78). **Plans cannot adjust or void encounters that are in location 42/78**. Trying to adjust an encounter that has been withdrawn (42/78) will pend the encounter for H280.

Also, verify that the encounter to be adjusted has the same Health Plan ID, and Provider ID as the original encounter. If you are unsure of the status of the encounter you are working on, refer to PMMIS screen EC510.

AHCCCS ENDS COVERAGE OF NORPLANT INSERTION

As of 09/01/2002 Norplant insertion is no longer an AHCCCS-covered service. AHCCCS has ended coverage because the manufacturer, Wyeth, is no longer distributing Norplant in the United States.

Providers must not bill the AHCCCS Administration or its contractors for CPT codes 11975 (Insertion , implantable contraceptive capsules) and 11977 (Removal with reinsertion, implantable contraceptive capsules).

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P285 – SPLIT BILL FOR PROVIDER ID CHANGE

For P285 (Split Bill for Provider ID Change) pended encounter provider enrollment information must be verified. Most often, an ownership or other change has resulted in provider termination of an identification number and a new provider number issued.

The provider identification number with effective dates maybe found on PMMIS PR070 screen. This information is also available on the monthly provider file from the FTP server.

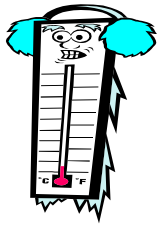
A sampling of terminated providers is listed below, along with the reason for termination and their effective dates.

Provider Id.	Provider Name	Reason for Termination	Effective Date of Termination
020157	St Joseph's Hospital-Phx	Termination-Ownership Change	09/30/2001
021361	Phoenix Children's Hospital	Termination-Multiple ID's (PMMIS)	05/24/2002
021387	Columbia PV Hospital	Termination-Ownership Change	11/01/2001
133017	Beverly Specialty Hospital	Termination-Ownership Change	07/31/1998
418229	Desert Willow Adult Care	Termination-Ownership Change	05/18/2000
531815	Desert Winds II	Termination-Ownership Change	08/07/2002

Note: The providers listed below with *'s have replacement provider id numbers.

525248*	Renal Care Group-South Phx	Termination-Ownership Change	08/21/2001
548349**	L & C Adult Care Home	Termination-Ownership Change	03/13/2002
574352***	Adams/Tracy M.	Termination-Provider Type Change	06/26/2002

* Replacement Provider Id 706749 Renal Care Group - South Phx Effective 08/22/2001
** Replacement Provider Id. 647042 L & C Adult Care Home Effective 03/14/2002
***Replacement Provider Id. 707383



New Edits

Effective with dates of service and receipt on and after January 1, 1995, edit U265 - Service Units Exceed Date Span, will be set to fail when the pricing revenue code units exceed the date of service span. For example Outpatient Dialysis (821, 841, & 851), Inpatient and LTC stays (accommodation).

Edit H115– Admit Date Must Be Within 2 Years of Service Begin Date, will be set to fail for inpatient and outpatient encounters when the admit date is not within 2 years of the service begin date. This edit will be bypassed for provider type 71 or 78. The edit will be set to soft for LTC form types.

AHCCCS streamlined and revised encounter valuation logic, i.e., how AHCCCS would reimburse encounters if paying on a Fee-for Service basis, to simplify processing logic and eliminate pended encounters for rate span errors. As a result it was necessary to set edits U265 and H115 to hard immediately in order to avoid system errors.

V151 (Operating Room Bill-ICD9 And/or HCPCS Must = Surgical) and V152 (Operating Room Bill-No Surgical ICD9 And/or HCPCS Code Present), will be added to the error code table in January 2003.

The difference between the two error codes are:

V151 - inpatient or outpatient with rev code 36X, will pend encounters when ICD9 procedure code is present, and surgical ICD9 procedure code is absent.

V152 - inpatient or outpatient with revenue code 36X, will pend encounters when there are not any ICD9 procedure codes present.

Effective with dates of service on and after April 1, 1999, emergency transportation providers, type 06, may report CPT code Z3621 (Ambulance Van, Urban Base Rate).

Place of Services

Effective with dates of service on and after January 1, 2002 the following CPT codes can be reported with a place of service code 11-Office:

- 43235 Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)
- 49422 Removal of permanent intraperitoneal cannula or catheter

Procedure Codes for Podiatrist

Effective for dates of service July 1, 2002 Podiatrist (provider type 10) can use the procedure codes:
12020 – Treatment of Superficial Wound Dehiscence; Simple Closure
12021 – Treatment of Superficial Wound Dehiscence; With Packing
97110 – Therapeutic Procedure, One or More Areas, Each 15 Minute

Additional CPT Code Added to Provider Type 10-Podiatrist

To align with Medicare billing practices, effective with dates of service on and after January 1, 2002 Podiatrists may report CPT code 64640 (Destruction by neurolytic agent: other peripheral nerve or branch).

Change in Place of Service

Effective with dates of service on and after December 12, 2002 the following CPT codes will no longer be available in the listed place of service:

- 95806 Sleep study, simultaneous recording of ventilation, respiratory effort, ECG or heart rate, and oxygen saturation, unattended by a technologist; end-dated place of service code 99, Other unlisted facility
- 95810 Polysomnography; sleep staging with 4 or more additional parameters of sleep, attended by a technologist; end-dated place of service code 12, Home
- 95811 Polysomnography; sleep staging with 4 or more additional parameters of sleep, with initiation of continuous positive airway pressure therapy or bilevel ventilation, attended by a technologist; end-dated place of service code 99, Other unlisted facility
- 95819 Electroencephalogram (EEG) including recording awake and asleep (including hyperventilation and/or photic stimulation when appropriate); end-dated place of service code 11, Office
- 95822 Electroencephalogram (EEG); sleep only; end-dated place of service code 11, Office
- 95830 Insertion by physician of sphenoidal electrodes for electroencephalographic (EEG) recording; end-dated place of service code 11, Office

Coverage Code Change

Effective with dates of service on and after September 30, 2001 the coverage code 04 (Not Covered Service/Code Not Available) was changed to coverage code 03 (Covered Service/Use Other Code) on the following HCPCS codes:

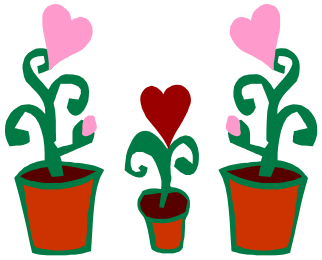
- A4580 Cast Supplies (e.g. Plaster); use appropriate Q-code as listed in HCPCS
- A4590 Special Casting Material (e.g. Fiberglass); use appropriate Q-code

Effective with dates of service on and after March 1, 2003 the following CPT codes will no longer be available, i.e., the coverage code changed to 04 (Not Covered Service/Code Not Available):

- 96150 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysicological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; initial assessment
- 96151 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysicological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient; re-assessment
- 96152 Health and behavior intervention, each 15 minutes, face-to-face; individual
- 96153 Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients)
- 96154 Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present)
- 96155 Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present)

Revenue Codes Added

Effective with dates of service on and after October 1, 2002 trauma center revenue codes, 680 - 689, can be reported on the UB92 form.



Excluded Surgical Tier Procedure Codes

The following ICD-9 procedure codes for 2003 will be added to the excluded surgery table (RF724 and RF606):

00.01-00.09	Therapeutic ultrasound
00.10	Implantation of chemotherapeutic agent
00.11	Infusion of drotrecogin alfa
00.12	Administration of inhaled nitric oxide
00.13	Injection or infusion of nesiritide
00.14	Injection or infusion of oxazolidinone class of antibiotics
00.50-00.54	Implantation of cardiac resynchronization defibrillator
00.55	Insertion of drug-eluting non-coronary artery stent(s)
36.07	Insertion of drug-eluting coronary artery stents(s)
39.72	Endovascular repair or occlusion of head and neck vessels
88.96	Other intraoperative magnetic resonance imaging
89.60	Continuous intra-arterial blood gas monitoring
99.76	Extracorporeal immunoadsorption

The following procedures will be non-covered until further research is done:

00.01-00.09	Therapeutic ultrasound
00.55	Insertion of drug-eluting non-coronary artery stent
36.07	Insertion of drug-eluting coronary artery stent

Modifier Availability

Effective with dates of service on and after January 1, 2001 modifier HH (Discharge/transfer from one hospital to another hospital) can be reported with transportation HCPCS code A0429 [Ambulance service, basic life support, emergency transport (BLS-emergency)].

Limits Changed

The "Procedure Daily Maximum" has been changed from 7 to 120 a day, HCPCS J9100 (Cytarabine, [Cytarabine Hydrochloride]; 100 mg).

Place of Service

The following CPT codes can be reported with a place of service 23 (Emergency Room):

- Effective with dates of service on and after January 1, 2002 CPT code 46040 [Incision and drainage of ischiorectal and/or perirectal abscess (separate procedure)]
- Effective with dates of service on and after January 1, 2001 CPT codes:
  - 44500 Introduction of long gastrointestinal tube (eg, Miller-Abbott)(separate procedure)
  - 36216 Selective catheter placement, arterial system; initial second order thoracic or brachiocephalic branch, within a vascular family
  - 36217 Selective catheter placement, arterial system; initial third order or more selective thoracic or brachiocephalic branch, within a vascular family
  - 36218 Selective catheter placement, arterial system; additional second order, third order, and beyond, thoracic or brachiocephalic branch, within a vascular family (List in addition to code for initial second or third order vessel as appropriate)

Modifier Availability

Effective with dates of service on and after January 1, 2002 modifier RT (Identifies Right Side Body Procedures) and LT (Identifies Left Side Body Procedures) can be used with the following CPT codes:

- 35201 - 35286 Repair of blood vessel other than for fistula, with or without patch angioplasty. Please see each code in range for exact description.
- 37615 Ligation, major artery (eg, post-traumatic, rupture); neck
- 37616 Ligation, major artery (eg, post-traumatic, rupture); chest
- 37617 Ligation, major artery (eg, post-traumatic, rupture); abdomen
- 37618 Ligation, major artery (eg, post-traumatic, rupture); extremity

Unit Changes

The procedure daily maximum units have changed to 25 for Flow cytometry CPT codes 88180 and 88182.

Age Limit Changes

The minimum age limit has been lowered on the following diagnosis codes:

- 995.80 to 995.89 Adult abuse; Please see each diagnosis code for an exact description; minimum age limit lowered to 15 years
- 624.8 Other specified noninflammatory disorders of vulva and perineum; minimum age limit lowered to 000 years

Edit Updates

Edit D131 (Diagnosis is not Appropriate for this Service) will be set to active status effective 03/01/2003. This edit will be used to validate that no professional and/or institutional providers utilize diagnosis code 799 to 799.9 as the primary or admitting diagnosis. This check does exclude non-emergency transportation service billings. This pend error code will be overridden, on a case-by case basis, by the Encounter Unit technical assist personnel.

Additional HCPCS Codes Added to Provider Type 8-MD Physician and 31-DO Physician Osteopath

The following HCPCS codes are available to be reported by MDs and DOs. The effective dates vary, please see individual codes for dates, coverage information and descriptions:

- Q2001 to Q2017
- Q2019 to Q2022
- Q3001 to Q3012